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November 10, 2011

MEMORANDUM

TO:
Joint Legislative Oversight Committee Members on HHS
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

Steven Jordan SJ

SUBJECT: Implementation Update #92

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Health Choice Claims Denial/Retro Auth.
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Critical Access Behavioral Health Agency Rules

The **Critical Access Behavioral Health Agency (**CABHA) temporary rules expired on October 15, 2011. The permanent rules and fiscal note are in the process of going through the Office of State Budget and Management (OSBM) and the Rules Review Commission. They will be posted for public comment and will have a public hearing in line with the permanent rule process. The CABHA infrastructure, core services, and CABHA-only services are delineated in the Medicaid State Plan and were approved by the Centers for Medicare and Medicaid Services (CMS).

The Medicaid State Plan also states, "A Critical Access Behavioral Health Agency must meet all statutory, rule and policy requirements for Medicaid mental health and substance abuse service provision and monitoring; be determined to be in good standing with the Department, and have a three year (or longer) accreditation from an accrediting body recognized by the Secretary of the Department of Health and Human Services. State statutory

requirements regulating the provision of mental health and substance abuse services are in North Carolina General Statute, Chapter 122C; administrative rules relating to these services are in 10A NCAC 27 and clinical policy requirements are specified in Medicaid Clinical Policy Section 8. Medicaid and enrollment policy require compliance with Federal Medicaid Policy relating to confidentiality, record retention, fraud and abuse reporting and education, documentation, staff qualifications and compliance with clinical standards for each service."

CABHAs are reminded that they agreed to comply with the CABHA temporary rules when they achieved CABHA status. The expectation is that providers will continue to uphold CABHA standards set forth in those rules and in implementation updates issued by the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). Furthermore, the Medicaid Provider Agreement requires Medicaid providers to comply with the Social Security Act, the North Carolina Medicaid State Plan and any waivers, HIPAA, FERPA, N.C.G.S. 108A-80, and "state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered" if the foregoing is "consistent with and expressly or implicitly authorized" by "Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, [and] any Title XIX waivers authorized by" CMS. Implementation updates and policy statements regarding CABHA requirements are implicitly authorized by the State Plan and must be adhered to by providers.

Extension of Current CAP-MR/DD Waiver and Process for Submitting Authorization Requests

The Division of Medical Assistance has asked CMS for an extension for the current 2008 CAP MR/DD waiver. The extension was requested because DMA and DMH/DD/SAS are working with CMS to review NC's progress on our 2008 CAP MR/DD waiver transition plan for recipients residing in facilities with more than 16 beds and the Divisions are addressing final questions about transition to the new waiver requirements.

When the waiver is approved by CMS, DMA will publish the final services with the effective start date of the waiver. The proposed implementation date for the renewal CAP I/DD waiver is January 1, 2012.

We appreciate the amount of time that recipients, families, case managers, and providers have spent working on developing transition plans. To that end, we have drafted the following guidelines in an attempt to minimize further disruption for recipients and their families. Please review the following bullets to determine if the case manager and recipient/family need to submit an updated revision (authorization request), including the person centered plan (PCP) revision form with appropriate signatures, CTCM form, and updated cost summary.

- If services were authorized to fit the new waiver requirements and the recipient/legally responsible person accepted the plan/services, then a revision (authorization request) does not need to be submitted. Specifically, if a request to change Home Supports services to Home and Community Supports and Personal Care has been approved, those services can be provided effective November 1, 2011.

- If services currently authorized under the 2008 CAP MR/DD waiver are not in compliance with the new proposed waiver requirements, then a revision (authorization request) does not need to be submitted at this time. A revision for authorization of new services must be submitted by January 1, 2012 to have services meet the requirements under the new waiver.

- If an authorization request was approved to change services to meet the new waiver requirements, and the recipient/legally responsible person would rather continue with their current services under the 2008 CAP waiver, then the case manager needs to document this information into a case management note and update the PCP and cost summary for the recipient record. This updated PCP will serve as the authorization in the interim until January 1, 2012. The case manager does not submit this information to the utilization review (UR) vendor. The plan that was to go into effect on November 1, 2011 will now go into effect on January 1, 2012.

- If a revision request was sent to the UR vendor to change services to meet the new waiver requirements, the UR vendor will process the request with an effective date of January 1, 2012. The case manager will need to contact the UR vendor if they would like the request that was submitted to be effective November 1, 2011 instead of January 1, 2012.

- If a CNR (yearly renewal) with an effective date of November 1, 2011 has been approved or is currently being reviewed by a UR vendor, and the recipient/legally responsible person would rather continue with their current services, then the case manager needs to update the PCP and cost summary to show two months of services under the current waiver and ten months of services in compliance with the requirements of the new waiver. This updated CNR must be submitted to the UR vendor by January 1, 2012.

If you have any questions, please contact the Behavioral Health Section of DMA at (919) 855-4290.

Health Choice Claims Denial and Retro Authorization for Services

Temporary Denial of Select Claims
Due to a systems start-up issue, the following codes denied for reimbursement as non-covered services for Health Choice recipients. These services **are** covered for Health Choice recipients and the systems' problem has now been corrected. Providers may re-submit claims that were previously denied as non-covered services. This notice relates only to claims for Health Choice recipients and only for claims that denied for this reason. This notice does not impact claims denied for Medicaid recipients or claims denied for other reasons. We regret any inconvenience this issue may have caused.

H0032	Targeted Case Management - Mental Health/Substance Abuse
T1017 HE	Targeted Case Management for IDD
S5145	Residential Services Level II, Family
H2020	Residential Services Level II, Group
H0019	Behavioral Health Long Term Residential
T1023	Diagnostic Assessment
H2011	Mobile Crisis Management
H2012 HA	Child and Adolescent Day Treatment
H2022	Intensive In-Home Services
H2033	Multi-systemic Therapy (MST)

Health Choice Requirements Prohibiting Retro Authorization for Services
Please note: Health Choice is now operating under the same policies as Medicaid: effective immediately, all authorization requests for behavioral health services for children and adolescents covered by Health Choice must be approved PRIOR to the delivery of the service. The ONLY exceptions are for emergency and crisis services, per current Medicaid policy, and for situations in which a recipient receives retro-eligibility for Health Choice and the service has already been delivered. These requirements are the same that apply to Medicaid recipients and include Outpatient Services, Residential Services, Enhanced Services, Psychiatric Residential Treatment Facilities, Targeted Case Management and Inpatient Services.

With only the exceptions noted above, any other claims for behavioral health services submitted without prior authorization approval will be denied and no provision is allowed for retro-authorization after a service has been provided.

H Code Limits for Provisionally Licensed Professional Billing Through the LME

As stated in the June 2011 Medicaid Bulletin and Implementation Update #87, the coverage of provisionally licensed providers delivering outpatient behavioral health services as a reimbursable service under Medicaid funds and billed through the local management entity (LME) has been extended to June 30, 2012. There have been concerns voiced that the new changes in Clinical Coverage Policy 8C "Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers" that will be implemented in January 2012, eliminate this option for provisionally licensed professionals. As has already been the case, provisionally licensed professionals can either bill the allowable CPT codes 'incident to' a physician, or, they can bill H codes through the LME (if the LME allows for this type of billing). In line with the changes in 8C to be implemented in January 2012, in keeping with generally accepted guidelines for timeframes for outpatient services, and as a part of federal Medicaid fraud initiatives, the following limits will be placed on H codes billed through the LME:

- Individual and family therapy – can bill up to four units (60 minutes) per date of service (DOS) of the following codes as clinically appropriate: H0004, H0004HR, H0004HS
- Group therapy – can bill up to six units (90 minutes) per DOS of the following codes as clinically appropriate: H0004HQ, H0005
- Assessment – can bill up to eight units (120 minutes) per DOS of the following codes as clinically appropriate: H0001, H0031

Providers are still responsible for counting unmanaged visits and obtaining prior authorization as needed.

Resolution for IPRS and Medicaid Claim Denials

DMA has determined system modifications were required to address the denial of claims billed through the LME for Therapeutic Foster Care and Outpatient Behavioral Health services provided by provisionally-licensed individuals. These denials began appearing in April up until the present. The system's issue has been resolved so that claims that were denied during that period may be resubmitted. For denied therapeutic foster care claims for S5145, the LME should resubmit the claim with the correct attending National Provider Identifier (NPI) for the service provided. For denied outpatient claims for provisionally licensed professionals, the LME should return the claim to the provider and have them resubmit the claim under the enrolled NPI. Questions should be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

Cardinal Innovations Health Plan (Formerly the NC MH/DD/SAS Health Plan)

Effective July 1, 2010, all services provided in the emergency department (ED) during an admission with a primary discharge diagnosis of 290 through 319 were added to the Cardinal Innovations Health Plan 1915 b/c Waiver Capitation rate. The Cardinal Innovations Health Plan has been in operation in Cabarrus, Davidson, Rowan, Stanly, and Union counties. Medicaid originating from Alamance and Caswell counties became part of the Cardinal Innovations Health Plan effective October 1, 2011. Medicaid originating from Franklin, Granville, Halifax, Vance, and Warren counties will become part of the Cardinal Innovations Health Plan effective January 1, 2012. Medicaid originating from Orange, Person, and Chatham counties will become part of the Cardinal Innovations Health Plan effective April 1, 2012. The Cardinal Innovations Health Plan is administered by the area LME, PBH.

All ED fees for services provided in emergency rooms to Medicaid recipients residing in the PBH area with a primary discharge diagnosis in the 290 through 319 range**,** including professional and facility fees are to be billed to PBH as per the following schedule:

- Claims for Cabarrus, Davidson, Rowan, Union, and Stanly county Medicaid recipients from July 1, 2010 forward should be billed to PBH.

- Claims for Alamance and Caswell county Medicaid recipients from October 1, 2011 forward should be billed to PBH.

- Claims for Franklin, Granville, Halifax, Vance, and Warren county Medicaid recipients beginning January 1, 2012 forward should be billed to PBH.

- Claims for Orange, Person, and Chatham county Medicaid recipients beginning April 1, 2012 forward should be billed to PBH.

If you have been paid by Medicaid for an emergency room service that should have been billed to PBH, you will be subject to a recoup of Medicaid funds beginning January 1, 2012. You will then be able to bill PBH and be paid by them for these services. This would only apply to recipients whose Medicaid is active in the PBH catchment area. Please contact DMA Behavioral Health Section if you require further assistance at 919-855-4290.

Outpatient Behavioral Health Seminar Presentation

The presentation for the Outpatient Behavioral Health Seminars that will take place in early November can be found on the DMA website: http://www.ncdhhs.gov/dma/provider/seminars.htm.

Endorsement Time Frames Tripled

Effective the date of this Implementation Update, LMEs are authorized to triple the endorsement time frames until further notice. With LMEs involved in merger activities and 1915 (b) (c) activities the extension of the endorsement process will help the LMEs adequately evaluate provider qualifications for endorsement. We expect that LMEs will prioritize endorsement for evidence-based services or services that are critically needed within its catchment area. The authorization to triple the endorsement time lines apply to all time lines related to the LME's completion of the endorsement process. The triple time frame does not apply to provider wait time to re-apply if an endorsement is denied or withdrawn or the three year re-endorsement requirements and appeal process. Please refer to the endorsement policy found at:
http://www.ncdhhs.gov/mhddsas/providers/providerendorsement/policy-rev4-15-11providerendorse.pdf
for the existing time frames.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

As a reminder, all Medicaid-enrolled providers billing for services are expected to adhere to all Medicaid and Health Choice policies and guidelines and are expected to stay informed about any changes. Medicaid Bulletins are published monthly and may include articles not found in the Implementation Updates. Medicaid Bulletins can be found at: http://www.ncdhhs.gov/dma/bulletin/index.htm.

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